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Reducing a Hospital's Indwelling Urinary Catheter Utilization, "1 CAUTI-ous Step" at a Time

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Problem: A catheter-associated urinary tract infection (CAUTI) is the fourth most common type of hospital acquired infection (HAI) and the cause of 93,000 Urinary tract infections in the acute care hospital setting (CDC, 2011). It is one of the most common and expensive health- care associated infections reported by the National Health Safety Network (NHSN). This problem is at the heart of the nurse's work in a hospital. How can CAUTI's be avoided and how can we learn from the CAUTI's that do occur?

Introduction: Our hospital strives to meet the goal of providing high quality and safety standards for every patient, every day. Prior to the initiative, the role of the bedside nurse was limited to general communication with the provider. The CAUTI-specific nurse champion responsibilities were not identified or empowered as an important part of our culture. The role of Infection Prevention (IP) had limited nurse interaction as they did not use a coordinated process to review CAUTI infections in-depth to identify causes. Initially at the beginning of this journey a standard indwelling urinary catheter utilization ratio metric was not implemented at the time to track urinary catheter usage on the units, and alternative external urinary devices for females were not available. Along the way, several initiatives have contributed to the reduction of the CAUTI rate and indwelling urinary catheter (IUC) standard utilization rate over the last several years.

Approach to Problem: To reduce our CAUTIs, several initiatives, including but not limited to the Nurse-Driven Urinary Catheter Removal protocol, development of the CAUTI nurse champion role, bi-weekly CAUTI leadership rounds, and formal interdisciplinary CAUTI Apparent Cause Analysis (ACA) Review with leadership and staff were initiated. The formal review process and strategic education for these CAUTI initiatives included involvement from unit leadership (including CAUTI champion), medical staff, and executive team. All efforts were data-based and used clinical informatics reports to track improvements and identify areas of opportunities.

Conclusion: In 2019, our hospital's rolling 3-month standardized infection ratio (SIR) was >1 and not consistent throughout the year. During the pandemic in 2020, we saw an increase in our over-all SIR during the peak months of COVID-19. Despite an increase in the overall SIR, our facility maintained a rolling 3-month SIR of < 1. The number of CAUTIs were reduced by 20% within the female population and 8% within the male population.

Implications of the Solutions: The process barriers identified by nursing CAUTI champions allowed the CAUTI Team to identify defects and areas of opportunities that contributed to the decrease in the number of IUC's, and the number of CAUTIs identified. This journey led to a more multidisciplinary approach to reducing CAUTI infections and greater engagement/collaboration between the nurse at the bedside with infection prevention, physicians, and executive leadership.

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